



ANTHONY A. WILLIAMS
MAYOR

February 20, 2006

The Honorable David A. Catania
Chairperson, Committee on Health
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Dear Councilmember Catania:

In your letter dated January 27, 2006, you requested answers to a set of questions regarding the National Capital Medical Center Exclusive Rights Agreement, which was signed by me and President Swygert of Howard University in early January. Enclosed for your review is a joint response to those questions from the District and Howard.

Since the date of your letter, I submitted for the Council's consideration and approval a legislative package composed of six pieces of related legislation to ensure completion of the National Capital Medical Center (NCMC) project. My hope is that the enclosed answers will inform the debate about that legislative package. Our responses to your questions have enabled us once again to underscore the clear need for the proposed public-private partnership to develop The National Capital Medical Center (NCMC), as well as the need to move expeditiously to commence work on this vital initiative. The questions have also given us an opportunity to address some of the misimpressions that have been stated in the last several weeks about the proposal to create the NCMC.

I look forward to working with you, Chairman Cropp, and other members of the Council to move the NCMC legislative package forward, so we can ensure access to health services for residents across the District.

Sincerely,

A handwritten signature in cursive script that reads "Anthony A. Williams".

Anthony A. Williams

Cc: All Members of Council

INTRODUCTION

It is our pleasure to have this opportunity to respond to the submitted questions. These questions have enabled us once again to underscore the clear need for the proposed public-private partnership to develop The National Capital Medical Center (NCCM), as well as the need to move expeditiously to commence work on this vital initiative. The questions allow the opportunity to address some of the misimpressions that have been stated or reported in the last several weeks about the proposal to create the NCCM.

In addition to responding to each individual question below, it may be helpful to members of the Council and other interested parties to have a brief summary of some of the key issues raised. In particular, this introduction addresses the role of the NCCM; the anticipated return to the City for its proposed investment; the expected role of the NCCM in caring for the underserved; and the justification for the requested exemption from the Certificate of Need (CON) process.

What is the NCCM?

The NCCM is the result of a proposed public-private partnership between the District of Columbia (District) and Howard University (Howard) to develop an integrated health system that will be a national model for urban cities. It will include enhanced preventive, primary and specialty care services; a medical office building; and a research facility, in addition to a new inpatient facility. The NCCM will provide a carefully selected range of inpatient, specialty, outpatient, and emergency and trauma services, drawing upon both community-based and Howard physicians. The NCCM is being designed with state-of-the-art medical equipment, and the highest quality patient safety and clinical information systems. It will be an efficient and attractive healthcare environment that will be both patient- and physician-friendly.

What return can the District expect for its proposed investment?

The District will see a substantial return, well beyond the proposed \$212 million investment. The NCCM will be the linchpin of a bold new community-based system of care with a focus on prevention and wellness. The goal of the District's partnership with Howard is improved outcomes and health status for the residents of the most medically underserved parts of the District. The NCCM will have the capacity to support and enhance the District's Medical Homes network, especially for lower income patients. This project will also serve as an economic engine to enhance the transformation of the surrounding community into the planned mixed-use Anacostia Waterfront District.

In addition to the expectation that the NCCM will provide a substantial proportion of uncompensated care to low income District residents, the following additional benefits should be taken into account in measuring the District's anticipated return:

First, the District will be obtaining a new, privately operated Level One trauma facility, as part of a comprehensive, high-quality medical complex costing substantially more than \$212 million. At present, a dangerous situation exists in the District because emergency and trauma services are not spread evenly across the city. Each day, ambulances must travel great distances to bring patients to emergency care facilities, especially for high-level trauma care. All three of

the District's verified Level One trauma centers (Children's National Medical Center, Howard University Hospital, and Washington Hospital Center) are located within a mile of each other in the Northwest quadrant of the city. The NCMC proposal will move one of the three Level One trauma centers to the east side of the city, which will be more accessible to many residents and will ensure multiple access points to trauma care in the event of a major disaster.

Second, with the reconfiguration of Howard University Hospital (HUH) and the transfer of a number of services from a medically congested area to an underserved part of the city, the District will realize a more equitable distribution of medical services in the city - with no increase in the number of licensed beds. The NCMC will be located in an area of considerable need. While the District has an abundance of primary, hospital and specialty care providers in certain areas, many neighborhoods of the District are underserved, based on one of several federal standards. According to the Federal Health Resources and Services Administration, 107 of the District's 192 census tracts are designated as Health Professions Shortage Areas (HPSAs), including Reservation 13; and 78 are considered Medically Underserved Areas (MUA), implying that a significant portion of the city's population is without adequate access to care. The vast majority of the HPSAs and MUAs are located in the District's eastern quadrants. In a city rich in medical resources, it is painfully evident that the geographic distribution of providers does not align with the distribution of the population, or the system's ability to meet healthcare needs. Additionally, the uneven distribution of healthcare means that many low-income residents face multiple barriers in accessing primary and preventive care.

Third, the NCMC campus will include a medical office building that will bring badly needed specialty services to this part of the city, and support an expanded primary care network in the District's most underserved wards. The NCMC will also include a research facility that will focus on disparities in health status and outcomes among the low income and minority populations that will be served by the NCMC. The District will not contribute funds to build either the medical office building or the health research facility, both of which will be fully funded from private resources.

Fourth, as HUH is the only university-sponsored hospital in the city, the District will benefit substantially from the ramping up of Howard's historic, 143-year tradition of patient care, medical education and training, at a time when both the District and the nation are anticipating severe shortages of physicians, nurses and other skilled ancillary health workers generally, and of minority providers in particular.

Fifth, District residents will benefit substantially from the anticipated emphasis at the NCMC on the health status of, and particular medical problems faced by, lower income and minority patients. It is anticipated that the NCMC will be a major center for both research and patient care targeted toward health disparities, outcomes and chronic disease management, with the resulting ability to reduce the time it takes for research findings to go from "bench" to "bedside."

Sixth, it is anticipated that the District will experience a substantial return from the ability of the NCMC to serve as an anchor for primary care providers and the city's Medical Homes initiative, including both the development of new primary care capacity as well as the building of linkages between primary care and access to specialty services.

Finally, the NCMC expects to generate other substantial economic and social returns, both for its immediate community and for the entire District. These include creating 1,800-2,700 construction jobs and 1,200-1,800 permanent skilled jobs; serving as a major foundation of an improving neighborhood; and adding state-of-the-art facilities to enable the District to compete more effectively with major medical “centers of excellence” being created (and aggressively marketed) in other cities in the region.

What is the NCMC’s anticipated role in caring for underserved District residents?

Since 2003, the Mayor has consistently said that the NCMC will not be just a “poor person’s hospital”. The goal of the District’s investment in the NCMC has never been to create a source of care for the uninsured; the District’s policy for care for low to moderate income residents is to offer comprehensive health coverage, with choice of provider, rather than one public institution designated to care for all uninsured and underinsured patients. Coverage alone, without accessible healthcare providers, does not adequately address care for chronic conditions and leads to more expensive healthcare delivery in the long term. The District’s investment in the NCMC is intended to create a more even distribution of healthcare resources across the city, so that access to the appropriate level of care is available to residents in the Northeast and Southeast. The NCMC will offer residents of the east side of the city, who have the highest prevalence of chronic illness, Level One trauma and inpatient care; specialty and diagnostic services; and follow-up care in physician offices.

To be able to carry out its multiple missions and serve the residents of both its neighboring communities and the District as a whole, the NCMC will clearly need to share the burden of uncompensated care with other nonprofit hospitals in the District. Due to its location, anticipated service mix and mission, and based on the historical experience of HUH, we fully expect that the NCMC will provide a substantial proportion of care to the underserved in the city when it opens.

The fact is that no hospital in the District - even D.C. General before it closed - has ever served as the “sole provider” responsible for care to the District’s uninsured and underinsured residents. This fact is underscored by a review of the mission and experience of HUH. According to data recently reported by the District of Columbia Hospital Association (DCHA), while Howard has 10.8% of the city’s non-federal acute care beds, it incurred 24% of the city’s uncompensated hospital costs in 2004. The Washington Hospital Center has 31% of the District’s beds, but reported only 17% of the District’s uncompensated costs in 2004. Further, among the District’s major teaching hospitals, DCHA reports that in 2004 17.5% of HUH’s total costs were uncompensated, as compared with just 4% of costs for the Washington Hospital Center, 3.2% for Georgetown, and 2.6% for George Washington. The citywide average in 2004 was 7.4%.

Both the District and Howard understand that the NCMC will serve a community that includes a substantial proportion of the District’s publicly funded, uninsured and underinsured patients. The Exclusive Rights Agreement (ERA) requires Howard to develop a public health operating plan, including a plan to develop a continuum of care for specialty services and effective follow-up with primary care providers; a plan to reduce the number of emergency room visits and ambulatory sensitive hospital admissions; and a program to provide emergency

healthcare for the underserved, regardless of ability to pay. The ERA also requires the NCMC to develop a policy for patient billing and collections practices which will be the one of the most progressive in the nation. For example, the NCMC must have reasonable fee schedules for uninsured patients, rather than billing “charges”, as most hospitals currently do. In addition, all collections policies must take into account the patient’s (and his or her family’s) income and other financial resources. The District must approve all of these plans.

Why is the District requesting a Certificate of Need exemption?

The CON is a regulatory process used by some states to decide whether a proposed new healthcare facility is needed. The Federal government used to mandate that states implement CON programs as a condition of Medicare and Medicaid funding. However, the Federal CON law has long since been repealed, and there is no evidence that the CON process helps to control costs.

The Mayor is recommending that the Council exempt the NCMC Project from the CON process for several reasons:

First, it is the District government itself that has determined that there is a compelling public need to develop a privately operated, state-of-the-art health system on this site. By proposing to fund half of the construction cost of the NCMC, the District has determined that it is in the best interest of the city to get the proposed new services to the community as soon and as cost-effectively as possible. Because the NCMC is a public-private partnership, it is subject to substantial public review and analysis by the D.C. government.

Second, the District Council itself has had ample opportunity to consider the potential need for the NCMC, and has already voted twice to endorse the proposal to build a new hospital with Howard. In November 2003, the Council passed an emergency resolution that stated, “[t]he District’s existing healthcare infrastructure is inadequate in part because of the uneven distribution of hospitals throughout the city.” The resolution also stated that any agreement with Howard should include a long-term lease of land for the new hospital, District financial support for construction of the new hospital, a provision that the District shall not manage or operate the hospital, and a statement of the hospital’s commitment to serve the underserved. Subsequently, in May of 2004, the Council unanimously approved a Memorandum of Understanding which restated the basic terms of the emergency resolution, including a statement that the National Capital Medical Center would be a Level One trauma hospital with 200 to 300 beds. All of these terms have been successfully negotiated with Howard, and are reflected in the legislative package submitted to the Council for approval on February 7th.

Third, the Mayor is concerned about the delay that will inevitably result from the CON’s lengthy appeals process. The District CON law allows for three layers of appeals that could take anywhere from two to six years to resolve. There are a number of examples of CON applications that have been delayed in the appeals process for several years: Fresenius Medical Care – 2.5 years; Sibley Hospital – 2.5 years; Washington Healthcare Group – 2.5 years and counting; and Good Hope Institute – 7 years and counting. A delay of this nature would result in a higher price tag for the NCMC as construction costs rise each year, and it would significantly delay the implementation of needed health services.

Fourth, the NCMC will be subject to a rigorous programmatic, financial and architectural/engineering review by the Federal government in order to qualify for FHA mortgage insurance. The U.S. Department of Housing and Urban Development, which administers the FHA program, will analyze the following at a minimum:

- Scope of the proposed NCMC
- Projected services
- Evidence of community need for the hospital and its services
- Construction alternatives considered
- Financial feasibility

Fifth, the beds and services in the proposed NCMC have already been determined to be needed at HUH, and the NCMC proposal does not request any new licensed beds. It merely transfers beds and services currently in HUH's license from an area where comparable services already exist, to an area closer to a population that has limited access to them.

In conclusion, the Council has the authority to make appropriate exemptions when there is a compelling public purpose and, in fact, has done so on occasion in the past. The Council has demonstrated that it is fully capable of representing the best interests of all of the residents of the District, including our most vulnerable and medically underserved populations.

COMMITMENT TO THE UNINSURED AND UNDERINSURED

1. *Please explain what constitutes “comparable” fee schedules for uninsured individuals and private third party payers as referenced in section 4.3.4(C) of the Exclusive Rights Agreement (“ERA”) for the National Capital Medical Center (“the NCMC”). Please provide the Committee on Health (“Committee”) copies of Howard University Hospital’s (“HUH”) existing fee schedules for uninsured/underinsured individuals and individuals with third party payers.*

Section 4.3.4(C) requires the NCMC to develop policies for patient billing and collection practices that shall include reasonable fee schedules for uninsured individuals that are comparable to the fees paid by third party private payers. The purpose of this section is to recognize that uninsured patients often lack sufficient leverage to negotiate the discounted payments which are often provided to third party payers, and to ensure that uninsured patients who are eligible for financial assistance are not subject to less favorable fee schedules than those used for patients with private third party insurance.

HUH’s current practice is to use the District’s Medicaid Fee Schedule for such uninsured patients. By using this schedule, HUH ensures that qualified uninsured patients never pay more than patients with private insurance.

Howard expects that the NCMC will use a similar system to ensure that its uninsured patients who are eligible for financial assistance never pay more than patients with private insurance.

Howard also expects that the NCMC will be at the forefront of hospitals nationally in providing charitable care. The ERA requires that the NCMC’s policies for patient billing and collection practices shall include eligibility for uninsured and underinsured individuals with incomes up to 400% of the Federal Poverty Level (FPL), which is higher than the current level at HUH; and for individuals whose income may exceed such limits, but whose medical expenses will deplete personal and family resources beyond a sustainable level. Finally, NCMC will also have collection policies that include payment plans that take into account the patient’s (and his or her family’s) income and other financial resources and obligations, and are monitored by the Board of the hospital.

In this regard, the NCMC’s policies are likely to be even more generous than the policies of many other health systems that are considered industry leaders in providing uncompensated care. For example, public hospitals such as Grady Health System in Atlanta and the Virginia Commonwealth University Health System Authority in Richmond offer sliding scale discounts up to just 200% of the FPL. Parkland Health and Hospital System in Dallas provides uncompensated care benefits to patients up to 250% of the FPL. In these health systems, patients above these FPL levels are billed full charges.

One model for the NCMC to consider is the Cambridge Health Alliance in Cambridge, Massachusetts, which offers free and discounted health services for qualifying uninsured and underinsured individuals. Under the program, patients below 200% of the FPL who are ineligible for Medicaid receive free care. Those between 200% and 400% of the FPL are eligible

for "partial" free care, and out-of-pocket expenses are capped. This type of policy would complement the District's Medicaid and Alliance programs, which provide health coverage to all residents under 200% of the FPL, by creating significant benefits for moderate income residents from 200% to 400% of the FPL.

The District's Medicaid Fee Schedule, which is over 100 pages, is being provided to the Council Chairman and the Committee Chair. On the advice of counsel, fee schedules for individuals with third party payers are not being provided due to existing confidentiality and non-disclosure agreements with many of the payers, and for competitive and potential anti-trust reasons.

2. *Please elaborate on the following from section 2.2.3 of the ERA:*

"The District acknowledges that the NCMC Hospital is not intended to be and shall not be the sole healthcare provider responsible for all uninsured, underinsured, and/or publicly insured patients in the District."

Since 2003, the Mayor has consistently said that the NCMC will not be just a "poor person's hospital."

The NCMC will be a private nonprofit hospital owned and operated by a new private, nonprofit healthcare organization. It is projected to draw a payer mix roughly similar to its service area: 32% Medicaid, 29% Medicare, 28% commercial, and 11% self-pay/uninsured.

The District's policy for care for low-income residents is to offer comprehensive health coverage with choice of provider, rather than one public institution designated to care for all low-income patients. Currently, the District is the only jurisdiction in the country that offers health coverage to all residents below 200% of the FPL, through Medicaid and the Alliance. The most recent analysis of the uninsured population in the District (completed by the Urban Institute) suggests that there are roughly 14,500 uninsured District residents between 200% and 400% of the FPL (about 2.5% of District residents). The policy of this Administration is to work toward achieving full coverage for all residents under 400% of poverty, rather than designate one medical institution that must treat uninsured residents free of charge. It is believed that this coverage approach will lead to more positive health outcomes, because low and moderate income residents will have full access to primary care, specialty care, and hospital care, as well as choice in the provider that they use. Creating an institution designated to serve all of the District's uninsured or publicly insured residents, would move the District backward and in the direction of segregation of medical services for low-income patients.

Once the NCMC is built, Medicaid and the Alliance will continue to offer their members choice of hospital and physician, and the NCMC will not be under any obligation to serve more Medicaid and Alliance patients than choose to be served there. In addition, uninsured patients will also continue to have a choice of which hospital they use, since federal law requires all hospitals nationwide to receive and stabilize patients regardless of their insurance status. The District government will not direct uninsured patients to the NCMC.

No hospital in the District – even D.C. General before it closed – has ever served as the "sole provider" responsible for care to the District's uninsured and underinsured.

Recent history indicates that the burden of caring for the District's uninsured and underinsured population will continue to be shared by several of the city's hospitals. It is fully expected that the NCMC will provide a substantial volume of uncompensated services. This is because uncompensated care in the District has been historically skewed, determined largely by geography, and the historical mission of particular providers.

Prior to its closure, a substantial proportion of the city's uncompensated hospital care was provided at D.C. General. In 1998, for example, the Urban Institute reported that uncompensated care costs for all District hospitals in 1996 came to more than \$206 million. D.C. General provided \$74.2 million of that total and HUH provided the second highest total of \$35.5 million. The breakdown for other hospitals was as follows: Children's: \$22.4 million; George Washington: \$11.6 million; Georgetown: \$8.3 million; Greater Southeast: \$8 million; Providence: \$6.6 million; Sibley: \$4.8 million; and Washington Hospital Center: \$34.8 million.¹

Subsequent to the closure of D.C. General, the volume and proportion of uncompensated care changed dramatically for several District hospitals. Notwithstanding the Alliance and Medicaid coverage, the volume of uncompensated hospital care remains high. The DCHA reports that citywide uncompensated hospital costs grew from \$178 million in 2002 to over \$190 million in 2004. The most dramatic change from the D.C. General era was at Greater Southeast, which saw its uncompensated care grow from \$8 million in 1996 to over \$37 million in 2002, and over \$48 million in 2004. HUH also saw its uncompensated costs grow to over \$46 million in 2004. Washington Hospital Center initially grew to \$43 million in 2002, but following the closure of D.C. General, these costs decreased to \$31 million in 2004. Uncompensated care costs at other District hospitals during 2004 were: Children's: \$28.9 million; Georgetown: \$12.2 million; Providence: \$10.7 million; George Washington: \$6.4 million; and Sibley: \$4.8 million.

Both Howard and the District acknowledge that the NCMC, because of its location, progressive patient billing and collections policies, and Howard's historical mission, is likely to carry a sizable percentage of the District's charitable care. However, the goal of the NCMC has never been to finance free care for low-income District residents; that is the purpose of Medicaid and the Alliance. Instead, the goal of the NCMC is to provide access to a wide range of health services for residents on the east side of the District, regardless of their income or health coverage status.

3. *What will be the "proportionate share of public health services for the underserved" of the NCMC according to section 2.2.3? Who will determine what constitutes "proportionate"? Please define the term "underserved."*

a.) What will be the "proportionate share of public health services for the underserved" of the NCMC according to section 2.2.3? Who will determine what constitutes "proportionate"?

The term "underserved" in this sentence of the ERA refers to the uninsured, underinsured and/or publicly funded patients. The NCMC's "proportionate" share of those underserved patients will be the share of underserved patients that it draws based on market forces, including

¹ Ormond and Bovbjerg, "The Changing Hospital Sector in Washington, DC," The Urban Institute, 1998, available at <http://www.urban.org/UploadedPDF/dchosp.pdf>.

location, service offerings, etc. No government agency determines the specific share of services that must be offered by any other District hospital. The share of those services will be determined by the market, and may shift over time. Due to its location, anticipated service mix and mission, and based on the historical experience of HUH, it is fully expected that the NCMC will provide a substantial proportion of care to the underserved.

One way to determine whether or not the burden of a particular hospital is “proportionate” is to compare its proportion of citywide uncompensated costs to its proportion of beds. HUH, for example, has consistently provided uncompensated care well in excess of its proportion of the city’s beds – the only major teaching hospital in the city to do so. The DCHA reports that Howard has 10.8% of the city’s non-federal acute care beds, but incurred 24% of the city’s uncompensated hospital costs in 2004. The Washington Hospital Center, by contrast, has 31% of the District’s beds, but reported only 17% of the District’s uncompensated costs in 2004.

Another measure of “proportionality” would be the percentage of a hospital’s total costs represented by its uncompensated costs. Again, according to data recently reported by DCHA, in 2004, 17.5% of HUH’s total costs were uncompensated, as compared with just 4% of costs for the Washington Hospital Center, 3.2% for Georgetown and 2.6% for George Washington. The citywide average was 7.4%.

To be able to carry out its multiple missions and serve the residents of both its neighboring communities and the District as a whole, the NCMC will clearly need to share the burden of uncompensated care with other nonprofit hospitals in the District. However, it is fully expected that the NCMC will provide a substantial proportion of the city’s uncompensated services by any standard.

b.) Please define the term “underserved.”

The conventional use of the term “underserved” refers to areas where there are inadequate services available. The Shortage Designation Branch of the Bureau of Health Professions under the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services develops shortage designation criteria, and uses them to decide whether or not a geographic area or population group is a Health Professional Shortage Area or a Medically Underserved Area or Population.² These designations are important in determining the availability of federal funding for a variety of federal programs. A Medically Underserved Area (MUA) may be a whole county, group of counties or group of urban census tracts in which residents have a shortage of personal health services. Similarly, Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to healthcare. A Health Professional Shortage Area (HPSA) means any of the following, which the Secretary determines has a shortage of health professional(s): (1) an urban or rural area; (2) a population group; or (3) a public or nonprofit private medical facility. HPSAs tend to be divided into shortages of primary medical care, dental care and mental health providers.

² See HRSA Guidelines for Medically Underserved Area and Population Designation, available at <http://bhpr.hrsa.gov/shortage/muaguide.htm>.

While the District has an abundance of primary, hospital and specialty care providers in certain areas, many neighborhoods of the District are underserved, based on one or another of these federal standards. According to the HRSA, 107 of the District's 192 census tracts are designated as HPSAs, including Reservation 13 (located in Ward 6); and 78 are considered as MUAs/MUPs, implying that a significant portion of the city's population is without adequate access to care. The vast majority of the HPSAs and MUAs are located in the District's eastern quadrants. In a city rich in medical resources, it is painfully evident that the geographic distribution of providers does not align with the distribution of the population, or of the system's ability to meet healthcare needs. Additionally, the lack of adequate insurance coverage and uneven distribution of healthcare mean that many lower-income residents face multiple barriers in accessing primary and preventive care.

4. *According to section 2.2.3, "such obligation [for the underserved] shall remain the shared obligation of all healthcare facilities in the District." Why shouldn't the District expect to see a greater return, in terms of care to the uninsured, on its \$212 million investment (not including land and infrastructure improvements) than the amount currently required of all hospitals in the District?*

It is believed that the District's residents will see a substantial "return" on the District's investment, well beyond the proposed \$212 million expenditure. The NCMC will be the essential foundation of a community-based system of care, with a focus on prevention and wellness. The development of this system will not only lead to improved outcomes and health status for the residents of the most medically-underserved parts of the District, but will also have the capacity to support and enhance the District's Medical Homes network for lower income patients. If approved, this significant project will also serve as an economic engine to enhance the transformation of its immediate community into the planned mixed-use Anacostia Waterfront District.

The NCMC will clearly provide a substantial proportion of care to uninsured, underinsured and publicly funded District residents, given its location, progressive patient billing and collections policies, and Howard's historical mission to serve the underserved. However, the following additional benefits should be taken into account in measuring the District's anticipated "return":

First, the District will be obtaining a new, privately operated Level One trauma facility as part of a comprehensive, high-quality medical complex costing substantially more than the District's \$212 million contribution. At present, a dangerous situation exists in the District, because emergency and trauma services are not spread evenly across the city. Every day, ambulances must travel great distances to bring patients to emergency care facilities, especially for high-level trauma care. All three of the District's Level One trauma centers (Children's National Medical Center, HUH, and Washington Hospital Center) are located within about a mile of each other. The NCMC proposal will move one of the three Level One trauma centers to a different part of the city, where it will be more accessible to patients on the east side of the District, and will ensure multiple access points to trauma care in the event of a major disaster.

Second, the District will realize a more equitable distribution of medical services in the city with no increase in the number of licensed beds. It is important to note that the District's

policy to address the healthcare needs of low to moderate income residents is to offer comprehensive health coverage, with choice of provider, rather than one public institution designated to care for all low-income patients.

The goal of the District's investment in the NCMC (in conjunction with the District's primary care initiative - Medical Homes) is to create a more even distribution of healthcare resources across the city. Right now, because of the success of the Alliance and Medicaid, many residents on the east side of the city have an insurance card; however, they do not have physicians and hospitals to which to take that card, since there are few medical facilities in their neighborhoods. The NCMC will offer inpatient services, specialty services and diagnostic services to these patients, who have the highest prevalence of chronic illness in the city.

Third, the NCMC campus will include a medical office building that will help bring badly needed specialty services to this part of the city, and support an expanded primary care network in the District's most underserved wards. It will also include a research facility that will focus on disparities in health status and outcomes among the low income and minority populations that will be served by the NCMC. Both the medical office building and health research center will be fully funded from private resources.

Fourth, the District will benefit substantially from the revitalization of Howard's historic, 143-year old tradition of patient care, medical education and training, at a time when both the District and the nation are anticipating severe shortages of physicians, nurses and other skilled ancillary health workers generally, and of minority providers in particular.

Fifth, District residents will benefit substantially from the anticipated emphasis at the NCMC on the health status of, and particular medical problems faced by, lower income and minority patients. It is anticipated that the NCMC will be a major center for both research and patient care targeted on health disparities, outcomes and chronic disease management, with the resulting ability to reduce the time it takes for research findings to go from "bench" to "bedside."

Sixth, it is anticipated that the District will experience a substantial return from the ability of the NCMC to serve as an anchor for primary care providers and the city's Medical Homes initiative, including both the development of new primary care capacity as well as the building of linkages between primary care and access to specialty services.

Finally, it is fully expected that the NCMC will generate other substantial economic and social "returns", both for its immediate community and for the entire District. These include – but are not necessarily limited to – creating an estimated 1,800-2,700 construction jobs and 1,200-1,800 permanent skilled jobs; serving as a major foundation of an improving neighborhood; and adding state-of-the-art facilities to enable the District to compete more effectively with major medical "centers of excellence" being created (and aggressively marketed) in other cities in the region.

5. *Please provide the Committee copies of the specific language, documents, and/or sections of the following, as referenced in section 4.3.4(C):*

It should be noted that both the law and industry practices in this area are currently undergoing substantial and ongoing revision at the present time, due to a variety of factors.

These include the heightened attention of the Congress and regulators in the Federal Departments of Health and Human Services and Treasury, as well as of many state Attorneys General. As the answer to Question 1 above makes clear, when the NCMC's policies are developed, they will be based on both the law and best practices as articulated at that point in time.

(a) *Federal health care law*

Presently, both the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) have issued guidance with respect to billing policies and collection practices for uninsured and underinsured individuals. This guidance indicates that there is no restriction (under the Federal anti-kickback statute or the agency's own rules or regulations) prohibiting hospitals from offering discounts to uninsured patients unable to pay their hospital bills. Hospitals can waive collection, but must apply uniform collection practices to Medicare and non-Medicare patients in order to receive Medicare bad debt reimbursement. Hospitals must also report their full uniform charges on their Medicare cost reports, and not the discounted amounts.

(b) *Current best practices of charitable healthcare organizations*

The American Hospital Association issued a statement of principles and guidelines with respect to hospital billing and collection practices. These guidelines include:

- Communicating effectively: providing financial counseling to patients about their hospital bills; responding promptly to patients' questions about their bills; utilizing a clear, concise, and patient-friendly billing process
- Helping patients qualify for coverage: making information available on hospital-based charity care policies; communication of this information in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in the community; dissemination of policies with appropriate community health and human services agencies and organizations
- Ensuring hospital policies are applied accurately and consistently: hospitals should ensure that staff members working closely with patients are educated about hospital billing, financial assistance and collection policies and practices
- Making care more affordable for patients with limited means: hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care
- Ensuring fair billing and collection practices: hospitals should ensure that patient accounts are pursued fairly and consistently; hospitals should define standards and scope of practices to be used by outside collection agencies

(c) *IRS community benefit standards*

To qualify for 501(c)(3) tax-exempt status, an organization must serve a public purpose and must be organized and operated exclusively in furtherance of some charitable purpose. The promotion of health is considered by the IRS to be a charitable purpose. See Eastern Ky.

Welfare Rights Org. v. Simon, 506 F.2d 1278, 1289 (D.C. 1974), vacated on other grounds, 426 U.S. 26 (1976).

IRS Revenue Ruling 69-545 established a community benefit standard that a hospital must meet in order to qualify for 501(c)(3) exemption. A number of factors are used to determine whether a hospital promotes the health of a class of persons broad enough so that the community as a whole benefits.

The factors include:

- Is the Board of Trustees comprised of prominent citizens in the community (rather than exclusively members who are connected with the hospital)?
- Are medical staff privileges in the hospital available to all qualified physicians in the area?
- Is the hospital's emergency room open to all persons regardless of their ability to pay?
- Does the hospital use its operating surplus to expand/replace facilities, amortize indebtedness, and improve patient care, medical training, education and research?
- Does the hospital serve a broad cross-section of the community through research or charity care?
- If the organization is part of a multi-entity hospital system, do the corporate documents reflect corporate separateness?

In 2001, the IRS issued Field Service Advice that referenced the 501(c)(3) "operational test" which obligates a hospital to demonstrate that its charity care policies actually yield significant health services to the indigent in order to qualify for tax exempt status (as opposed to the hospital merely stating that its policies are designed to benefit the community).

More recently, in its Fiscal Year 2006 Exempt Organizations Implementing Guidelines released on October 25, 2005, the IRS announced a new focus on community benefit activities of nonprofit hospitals in 2006; it will begin sending letters to these hospitals asking about their community benefit practices as well as their executive compensation practices.

6. *According to the District's Home Rule Charter:*

"The Council shall have no authority to pass any act contrary to the provisions of this chapter except as specifically provided in this chapter, or to:...(2) lend the public credit for support of any private undertaking"; [D.C. Official Code § 1-206.02. (a)(2)]

As proposed in sections 2.2.3 and 4.3.4. (C) of the ERA, there will be no demonstrable increase in the level of public benefit (i.e., care for the uninsured) offered by the NCMC over the amount currently being provided. Has the District's Office of the Attorney General offered an opinion as to whether or not the current proposal constitutes a public or private venture and if the proposal, as presented, is legal under the Home Rule Charter? If so, please provide a copy of this opinion to the Committee.

The OAG has opined that the proposal is legal under the Home Rule Charter and the OAG's memo is attached.

As demonstrated in the responses to the preceding questions, there will be substantial public benefit from this Project, including care for the uninsured. The public benefit includes:

- the development of a new Level One trauma center;
- a more equitable distribution of medical services in the city with no increase in the number of licensed beds;
- a privately-funded medical office building that will bring badly needed specialty services to this part of the city, and support an expanded primary care network in the District's most underserved wards;
- a privately-funded research center that will focus on disparities in health status and outcomes among the low-income and minority populations that will be served by the NCMC;
- extending Howard's historic, 143-year tradition of patient care, medical education and training at a time when both the District and the nation are anticipating severe shortages of physicians, nurses and other skilled ancillary health workers generally, and of minority providers in particular;
- the emphasis at the NCMC on the health status of, and particular medical problems faced by, lower income and minority patients, such that the NCMC will be a major center for both research and patient care targeted toward health disparities, outcomes and chronic disease management;
- an anchor for primary care providers and the city's Medical Homes initiative, including both the development of new primary care capacity as well as the building of linkages between primary care and access to specialty services;
- the creation of a substantial number of new construction and permanent skilled jobs;
- an important foundation for the redevelopment of the surrounding neighborhood, and
- a new, state-of-the-art facility to enable the District to compete more effectively with other regional cities that have been developing and marketing major medical "centers of excellence."

In response to the specific question raised, the opinion of the Office of the Attorney General (OAG) is that the NCMC proposal is legal under the Home Rule Charter. An OAG memo states:

“The proposed grant agreement is an agreement to give a sum of money not to exceed a certain sum, subject to certain conditions. Such an agreement is not a lending of the public credit. A timely example of lending the public credit is the recent Council legislation approving the District’s guarantee of the obligations of the District’s Sports and Entertainment Commission to Major League Baseball (“MLB”) under the lease to MLB that was also approved by the Council. A common example of a lending of credit in the private sector is the execution of continuing and special guarantees as additional security for a borrower’s loans. Hence, the proposed grant agreement is not a violation of the District Home Rule Charter’s prohibition of lending the public credit to support a private undertaking.”

CERTIFICATE OF NEED

7. *Section 6.1 of the ERA conditions Howard University’s (“Howard”) obligation to undertake the project on the Council’s waiver of the Certificate of Need (“CON”) process. Will Howard proceed with the project if the Council does not exempt the project from the CON process?*

The financial commitments of the District and Howard in the ERA and the Grant Agreement are based on a construction schedule estimated in 2005, with inflation through 2007. In the current environment, construction costs are rising at approximately 5-10% per year.

Section 6.2.2 of the ERA says that adoption of the legislation by the District exempting the NCMC from the CON process is a condition precedent to proceeding to the construction phase. If the Council does not exempt the project from the CON process, Howard’s decision to proceed will depend on the financial feasibility of the Project with the increased construction costs as recalculated at the end of the CON process, and Howard’s need to make other strategic decisions for capital investments in HUH.

8. *According to section 2.1.3(v) an FHA feasibility study will be performed. Historically, these studies have been commissioned by states where there was no established CON process and paid for by the hospital seeking financing or through mortgage proceeds. In essence, as proposed in the ERA, the District would be exempting the project from the CON process only to commission a study intended to achieve the same results. What is the rationale behind taking this step?*

FHA requires that every applicant for mortgage insurance submit a feasibility study to FHA, regardless of whether or not a state CON process exists. As to the requirement that a state commission the required feasibility study, this requirement was superseded by a 2003 amendment to the National Housing Act which permitted individual hospitals in non-CON states to directly commission the required feasibility study.

The District is requesting an exemption from the CON process for NCMC in order to avoid the costly delays, both in terms of costs to the project and costs to the community, inherent in requiring NCMC to obtain a CON.

The District government itself has determined that there is a compelling public need to develop a privately operated, state-of-the-art medical complex on this site. By proposing to fund

half of the construction cost of NCMC, the District has determined that it is in the best interest of the city to get the proposed new services to the community as soon and as cost-effectively as possible. Moreover, because the NCMC is a public-private partnership, it is subject to substantial public review and analysis by the D.C. government, in addition to what would be required in the CON process.

The Council has already voted twice to endorse the proposal to build a new hospital with Howard. In November 2003, the Council passed an emergency resolution stating that, “[t]he District’s existing healthcare infrastructure is inadequate in part because of the uneven distribution of hospitals throughout the city.” Subsequently, in May of 2004, the Council unanimously approved a Memorandum of Understanding between the District and Howard that restated the basic terms of the emergency resolution, including a statement that the NCMC be a Level One trauma hospital with 200 to 300 beds located on 9 acres in Reservation 13.

The NCMC has also been the subject of Council hearings in July and October of 2005, and the legislative package currently before the Council could result in as many as nine more public hearings. Certainly thirteen hearings before the Council, and public meetings in every ward of the city, constitute a full review of the NCMC. Despite special interest opposition to this Project, at the grassroots level the residents of the District who would be most affected by the proposal strongly support the National Capital Medical Center.

To the extent that the Council continues to have concerns that the public debate intended by the CON process has not to date included other community providers and interested parties, it should be noted that FHA, as a part of its application process, typically interviews such parties to provide them an opportunity to express their views directly with respect to the NCMC. Additionally, the NCMC construction project will be subject to standard District construction oversight, including compliance with building code approvals, and employment/contracting rules and regulations.

The development of NCMC will not increase the District’s overall bed capacity. As stated in the ERA, as well as the proposed CON exemption legislation that accompanied Mayor Williams’ February 6, 2006 letter to Chairman Cropp, the combined number of beds at the NCMC and HUH after completion will not exceed HUH’s already existing 482-bed licensed capacity. As such, the NCMC project is more appropriately a reallocation of already licensed and CON-approved beds to the new Reservation 13 site.

The Mayor is concerned that the CON process, which includes three layers of appeals, could take as long as six years to complete. There are a number of examples of CON applications that have been delayed by the appeals process for several years: Fresenius Medical Care – 2.5 years; Sibley Hospital – 2.5 years; Washington Healthcare Group – 2.5 years and counting; and Good Hope Institute – 7 years and counting. These potential delays would significantly increase the project’s costs, making the NCMC no longer financially feasible, which in turn would continue the deprivation of critical healthcare services to the city’s most medically underserved.

The District believes that the FHA feasibility study will subject the NCMC to a thorough Federal review of its programmatic, financial and architectural/engineering plans, a review that

will be at least as rigorous as a CON examination, if not more so. FHA will analyze the following at a minimum:

- Scope of the proposed NCMC
- Projected services
- Evidence of community need for the hospital and its services
- Construction alternatives considered
- Financial feasibility

As the insurer of a multi-million dollar project construction loan and a fiduciary with respect to the federal government's General Insurance Fund, FHA will have no less an interest than the District's CON process in assuring the need for and, more importantly, the financial viability and success of the NCMC project.

The following table compares the District's CON examination with the factors considered in the FHA feasibility study.

COMPARISON OF CON FACTORS, FHA FACTORS AND ERA COMMITMENTS

CERTIFICATE OF NEED FACTORS	FEDERAL HOUSING ADMINISTRATION FACTORS	ADDITIONAL EXCLUSIVE RIGHTS AGREEMENT COMMITMENTS
Relationship of health services being reviewed to applicable Annual Implementation Plan and State Health Plan	Requires discussion of social service programs and any preventive medicine programs, such as prenatal and well-baby clinics, T.B. detection, nutrition and obesity clinics, and inoculation programs	Master Plan for Reservation 13, effective April 11, 2003 includes a hospital. NCMC to provide secure beds and inpatient psychiatric beds for the District
Relationship of services reviewed to the long-range development plan of person providing or proposing the services	N/A	Requires NCMC business and services plans that address impact of NCMC on Howard, in addition to other factors
Availability of less costly or more effective alternatives of providing proposed services	Requires that community needs be met in the most effective and economical manner	NCMC preliminary plans must include a public health operating plan that addresses the provision of care in the most efficient setting
Proposal's immediate and long-term financial feasibility and impact on NCMC's costs and charges	Requires NCMC to have systems that monitor its operations, revenues and costs accurately and timely; and has detailed examination of NCMC's financial feasibility	Requires the business plan to include pro forma financials for NCMC
Market need and demand for	Requires a feasibility study of the	Notes that D.C. Council

CERTIFICATE OF NEED FACTORS	FEDERAL HOUSING ADMINISTRATION FACTORS	ADDITIONAL EXCLUSIVE RIGHTS AGREEMENT COMMITMENTS
proposed services, with particular focus on underserved populations	market need that includes a service area definition, existing or proposed hospital designation as sole community provider, critical access hospital or rural referral center, and availability to Medicaid and uninsured patients	resolution No. 15-320, dated November 4, 2003, declares there is uneven distribution of hospitals in the District and that NCMC will expand care to underserved areas
Review of possible reduction or elimination of a service, including the relocation of a facility or a service	Considers migration of patients out of service area and requires NCMC to consider ways that eliminated services can be provided (e.g., through formal patient transfer agreements or service sharing agreements)	Provides for a plan for relocation of programs and services between HUH and NCMC
Contribution of the proposed service in meeting the health related needs of medically underserved groups that have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable Annual Implementation Plan and State Health Plan	Examines impact on disproportionate share hospitals. Importantly, FHA's mission is to promote hospital access in underserved areas and NCMC must support this mission.	Project includes a Level 1 trauma center, secure beds for correctional patients, involuntary psychiatric beds and other services not presently available in that area of the District. Substantive commitments to charitable care and financial policies for uninsured and underinsured.
Accessibility of services by underserved compared; performance in meeting charity care, availability of Medicare, Medicaid and medically indigent service; and multiple ways to access services	Examines impact on disproportionate share hospitals, encourages programs that provide essential services to all residents, regardless of ability to pay	Requires that the D.C. Health Care Alliance Program or its functional equivalent be maintained. Substantive commitments to charitable care and financial policies for uninsured and underinsured.
Proposed services compared to existing services	Considers market impact on existing healthcare providers	Limits the combined HUH and NCMC bed total to the total number of beds currently licensed to HUH
Availability of resources (personnel, capital funds, etc.) and alternative needs for such resources as stated in Annual Implementation Plan and State Health Plan	Requires organizational affiliations or relationships that optimize financial, clinical and operational performance and operation by management that is effective and efficient	

CERTIFICATE OF NEED FACTORS	FEDERAL HOUSING ADMINISTRATION FACTORS	ADDITIONAL EXCLUSIVE RIGHTS AGREEMENT COMMITMENTS
Relationship of proposed health services to ancillary/support services	Reviews outpatient volumes and availability of emergency services	
Consequences of proposed services on clinical training programs	Requires discussion of teaching hospital status	Howard acknowledges that its educational qualifications are a material consideration to the Agreement
Costs and methods of proposed construction and probable impact of construction on costs of providing health services	Requires NCMC to make certain project construction assurances, establishes construction standards, and mandates a detailed determination of financial feasibility that includes limits on historical operating margin and debt service ratio, a balance sheet cushion, and certain projected gains from operations, among other financial hurdles	Requires that Howard and the District negotiate a Development Agreement that governs NCMC's design, development, funding and construction
Effect of competition on the supply of health services	Examines competitors' occupancy rates, services offered, and utilization forecasts	
Improvements or innovations in financing and delivery of health services that foster competition and promote quality assurance and cost effectiveness	Requires detailed examination of financial feasibility, that includes limits on historical operating margin and debt service ratio, a balance sheet cushion and certain projected gains from operations, among other financial hurdles	Requires patient billing and collection practices that are consistent with current best practices of charitable healthcare organizations and IRS community benefit standards
History of quality of care	Requires favorable rating from Joint Commission on Accreditation of Healthcare Organizations	Notes that NCMC will expand quality and cost-effective healthcare services to underserved populations and Howard acknowledges that its health service qualifications and experience are a material consideration to the Agreement

9. According to the Hospital Mortgage Insurance Act of 2003 (P.L. 108-91), as a requirement to obtain financing under the HUD 242 program:

“The Secretary shall establish the means for determining need and feasibility for the hospital, if the State does not have an official procedure for determining the need for hospitals. If the state has an official procedure for determining the need for hospitals, the Secretary shall require that such procedure be followed before the application for insurance is submitted, and the application shall document that need has also been established under that procedure.”

What evidence is there that the HUD will approve an application for a hospital in a jurisdiction that maintains a CON process but waived this requirement specifically for the hospital for which financing is being requested? Please provide the name and position of any HUD officials with whom either the Mayor or Howard has consulted about the likelihood of such approval.

The question of whether or not the CON exemption will satisfy the National Housing Act requirements will be presented to the FHA as part of the overall NCMC application for mortgage insurance. Howard’s counsel has indicated that the National Housing Act gives deference to state law, and directs the Secretary of Housing and Urban Development to require hospitals to comply with local CON procedures. If an exemption as proposed for the NCMC by the Mayor is adopted by the Council, then there are no District CON procedures to be followed by the NCMC. Therefore, FHA may properly conclude that a CON will neither be available nor required for National Housing Act purposes.

FHA has specific procedures to consider projects in jurisdictions where no CON approval is required. In fact, about 25% of the projects approved by FHA for mortgage insurance over the past 5 years have not gone through a CON process.

10. *To obtain financing through the HUD 242 program, a hospital’s average operating margin for the preceding three fiscal years must have been equal to or greater than 0.00. What was the HUH’s net operating margin for Fiscal Years 2003, 2005, and 2005? Is it Howard’s expectation that the HUH’s annual federal subsidy be included in the calculation of this margin for the purposes of applying for HUD 242 financing?*

The historical operating requirement does not apply to the NCMC as a start-up institution. FHA’s operating margin requirement applies only to existing hospitals undertaking the substantial rehabilitation or replacement of its healthcare facilities. In the case of start-up facilities such as the NCMC, the FHA’s operating margin standards are guidelines and, when warranted by the specific circumstances of a project, may be modified.

HUH’s net operating margin for the years requested is shown on the financial statements being provided to the Committee in response to Question 32.

Howard receives an annual federal grant for medical education purposes. That grant has never been included in any NCMC financial projections provided by Howard.

11. *Is Council approval of the ERA required to apply for the HUD 242 program?*

No. The requirements for the HUD 242 program are set forth in Section 242 of the Housing Act, 12 U.S.C. 1715z-7. To be eligible for the financing, the applicant must be an existing or prospective licensed hospital.

12. *How long will it take to complete the application, feasibility study, and receive approval from HUD?*

The FHA process will commence after the Council adopts the Mayor's legislative package. It is expected that the development of a comprehensive financial feasibility study, the processing of the FHA application, and the structuring and closing of the construction loan and bond issue, will require about twelve to fourteen months to complete. That process includes the following steps:

1. Preparation of a financial feasibility study;
2. Preparation and submission of the FHA Application;
3. Receipt from FHA of its initial credit approval;
4. Receipt of a Guaranteed Maximum Price (GMP) for construction;
5. Receipt of FHA's Final Architectural approval;
6. Issuance of FHA's Firm Commitment to Insure the NCMC mortgage loan; and
7. Sale of tax-exempt bonds and the bond/loan closing.

The FHA financial feasibility study is a critical component of the mortgage loan application, and particular attention must be taken to ensure it addresses all of FHA's concerns. Once the legislative package is approved, the NCMC will solicit bids from qualified financial feasibility study consultant firms with experience in FHA programs. This process will take approximately one to two months. When the feasibility consultant is selected, it is expected that an FHA compliant financial feasibility study will require approximately three months to complete. During the period that the financial feasibility study is underway, Howard's financing team will coordinate the collection of all other materials required by the FHA application process so that the application itself may be delivered to FHA shortly after the feasibility study is received.

Once a completed FHA application is submitted, there are a series of independent processes that will be undertaken by FHA. Absent unforeseen circumstances during the application process, the FHA review and approval process, from submission of the application through loan closing, should take approximately seven to nine months. Set forth below are a summary of the steps involved in FHA's review of a hospital's application:

- FHA reviews the application for completeness within two weeks of submission. Upon being deemed complete, FHA will begin a substantive review of the application.
- The FHA will undertake its initial review of the project application, typically completed within one month. Shortly thereafter, FHA will schedule an onsite visit with the applicant and its advisors to both discuss FHA's initial questions, and to provide the applicant an opportunity to present its view of the programmatic, financial and architectural elements of the project. This site visit is expected to be a two-day meeting attended by NCMC management, the feasibility study consultant, the construction manager, the architect and NCMC's mortgage banker.

- FHA will develop any final open questions immediately after the site visit. Answers to FHA are typically sent within one month of receipt of FHA's questions.
- After any additional information is submitted, FHA will engage an independent consulting firm to conduct a desk audit of the financial feasibility study. Any questions raised by the "desk audit" will be addressed in a subsequent meeting among the parties. This process can take from one to two months, but can also run concurrently with the initial approval phase.
- If the Project is feasible, FHA's initial credit approval is typically granted within one month after completion of the independent desk audit.
- Typically a Guaranteed Maximum Price (GMP) will be provided by the applicant's construction manager during the application process, after plans and specifications for the project reach a biddable stage, normally at 80% completion. The applicant and its advisors intend to coordinate the development of plans and specifications and the receipt of a GMP, to assure its availability by the time the FHA feasibility and program review are complete and a desk audit issued. Once a GMP is received and the architectural elements of the project are approved (drawings, architect agreement, construction manager's agreement, etc.), FHA's final approval is granted. It takes approximately one month after receipt of the GMP to obtain FHA's Firm Commitment for insurance.
- Concurrently with the FHA review process, the NCMC financing team will be working to complete all required financing documents and obtain any other necessary approvals so that, upon issuance of a Firm Commitment, the underwriters may market the tax-exempt revenue bonds. Marketing of the bonds and a bond closing coordinated with an FHA mortgage closing can take approximately two months from receipt of a Firm Commitment. Upon closing, NCMC is permitted to commence construction of its facility.

COSTS AND FINANCING

13. An analysis by Stroudwater Associates in February 2005 found that under two of three different scenarios the NCMC would run operating deficits through year five. Under the only scenario to show a small profit in year five, the HUH would need to close completely and the totality of HUH's federal subsidies (\$30 million annual subsidy, plus all Disproportionate Share (DSH) payments) would have to be transferred to the NCMC. However, the July 12, 2005 submission to the Committee and the ERA, neither of which contemplates the complete closure of HUH, each forecast operating deficits for only two years, followed by profits in years three through five. Has the District retained Stroudwater or any other expert to analyze the actual likelihood of achieving a profit in years three through five under the scenario proposed in the ERA?

The District consultant's original analysis was completed without the benefit of internal Howard data such as reimbursement level, salary cost, planned service mix, etc. The consultant's early reports always carried caveats that they were "outside-in" analyses, and only

useful as a starting point for discussion. Howard subsequently produced much more detailed estimates, the conclusions of which were quite different from the initial high-level analysis completed by Stroudwater.

The differences in conclusions drawn from the February 2005 Stroudwater Report, as compared to the July 2005 financial projections prepared by Howard, are due to differences in demand, market share, service distribution and financial assumptions.

The Stroudwater assumptions included:

1. NCMC would be adding an additional 230 licensed beds to the system. The NCMC beds will come from Howard's existing licensed bed complement.
2. NCMC would have a new Level One trauma center, and HUH would retain its Level One trauma center, thus maintaining two very expensive and resource-intensive services. HUH will transfer its Level One trauma service to NCMC.
3. NCMC would replicate the DC General service area and volumes. Again, that is not our assumption. Stroudwater defined the NCMC service area very narrowly, as analogous to D.C. General when it was winding down in 2000. The July 2005 projections looked at DC General, but focused on its volume in 1998 and 1999, when D.C. General was at full volume and offered a broader array of services. In addition, unlike Stroudwater, Howard also assumed that residents close to D.C. General who were bypassing the hospital because of its "poor people's" stigma would use the NCMC. The total volume and service mix analysis yielded different results, including higher surgical volume and a more varied payer mix than D.C. General, and a more varied payer mix than Stroudwater assumed.
4. Stroudwater assumed that the NCMC staffing ratios would be analogous to HUH, using data from 2002. The July 2005 plan was based upon achieving staffing efficiencies between the NCMC and HUH, as well as service-mix adjustments.
5. Most significantly, at the time of the Stroudwater study in February, the assumption was that Howard would finance the full cost of the project. In essence, the ability of the NCMC to become financially self-sufficient can most clearly be tied to the difference between financing a \$400 million project which was Stroudwater's assumption in February, versus the need to finance only \$212 million after the District's contribution is received, as shown in the July 2005 projections.

The District did ask Stroudwater to evaluate Howard's July 2005 projections. Stroudwater did not fully replicate the more detailed analysis prepared by Howard. However, a follow up meeting was held with HUH, and the consultants discussed the assumptions made by Howard with respect to payer mix, outpatient surgical volumes, emergency department volumes, salary costs, and Disproportionate Share Payments.

14. Does HUH intend to transfer all or part of its annual federal subsidy (approximately \$30 million) to the NCMC? If a portion of the subsidy will be transferred, what will this amount be? What impact will the plan to reduce services at the HUH, as proposed in the ERA, have on this

subsidy? Has Howard received assurances from Congressional appropriators that it will continue to receive this subsidy in lieu of these service reductions?

Howard receives an annual federal grant for medical education purposes. The grant has never been included in any NCMC financial projections provided by Howard. Howard has made no plans to transfer the grant, which could only be done with the concurrence of the U.S. Congress.

15. *What payer mix was used in calculations showing a profit in year three at the NCMC?*

The table below shows the payer mix developed for the NCMC Demand Study prepared by The Lewin Group, dated March 2004, and used in the July 2005 financial projections. The NCMC payer mix assumptions presented in the table anticipate that about six out of every ten hospitalized patients will either have some form of public insurance or will qualify for uncompensated care. Nearly 80% of all specialty clinic services will be provided to patients with public insurance or who are uninsured.

National Capital Medical Center				
Payer Mix				
Year 3				
Description	Inpatient	ER	Clinics	Surgery
Payment Sources				
Medicare	26%	14%	30%	30%
Medicaid	21%	15%	18%	11%
Health Alliance	9%	12%	20%	15%
Managed Care	25%	20%	5%	20%
Blue Cross	8%	8%	8%	15%
Commercial	5%	7%	5%	7%
Self Pay & Charity	7%	25%	14%	1%
Total Payer Mix	100%	100%	100%	100%

16. *What is the estimated number of discharges per bed, average length of stay per bed, and net revenue per bed assumed in the calculations showing a profit by year three? What is the current number of discharges per bed, average length of stay, and net revenue per bed at HUH and for each District hospital and Prince George's County Hospital? By what percentage does the estimated net revenue per bed for the NCMC exceed or trail that of each District hospital and the Prince George's County Hospital?*

According to the industry standard benchmarks, NCMC's projected revenue margin is in line with other District hospitals. The industry standard benchmark is revenue per adjusted occupied bed, not net revenue per bed, which is a skewed statistic because it does not take into account occupancy levels. Rather than adding a large number of beds to meet demand, the NCMC expects to have a higher, more efficient occupancy of 80%. This compares with occupancy rates as low as 39% for other hospitals. As shown in the table below, while the NCMC's projected net revenue per bed appears to be on the high side, when it is adjusted based

on its projected average daily census, the revenue per adjusted occupied bed is exactly in line with other District hospitals.

National Capital Medical Center Selected Comparative Highlights							
Description	2005 Statistics		2003 Statistics				
	NCMC*	HUH	GW	Gtown	WHC	PGC	GSE
Discharge Per Bed	52	44	36	43	53	31	34
Average Daily Census (ADC)	185	218	N/A	220	610	220	177
Revenue per ADC	1,059,530	1,021,006	N/A	1,311,946	1,090,290	854,537	781,530
Occupancy %	80%	73%	N/A	66%	75%	39%	68%

* NCMC data is year 3

17 *In the October 27, 2005 submission to the Committee by the Mayor and Howard, contingency costs for the project were estimated to be 10 percent of the total project. In the ERA, this amount has doubled from \$21,200,000 (or \$10,600,000 per partner) to \$42,400,000 (or \$21,200,000 per partner). Please explain the reason for this increase.*

In the original NCMC facility cost estimate presented to the Committee in October 2005, the contingency fund was calculated as 10% of the “hard costs” of the project (i.e., actual construction costs, not including architecture and engineering fees, medical equipment, etc.), which totaled \$21,200,000 (or \$10,600,00 each). The contingency was increased to 20% to ensure that the budget would be sufficient to cover any unanticipated design changes.

The Grant Agreement states that the District’s portion of the contingency fund will only be spent if the full costs of the project are greater than \$381,936,000. In that case, the District will provide a contingency payment that is equal to or less than Howard’s contingency payment, but not more than \$21,200,000, regardless of the final cost of the project.

18. *On December 2, 2005, the Washington Times reported that HUH planned approximately 125 layoffs in the coming days. How many employees have been laid off since that time? Which positions were cut, and how much does the university plan to save through these measures? Please provide a full accounting of these layoffs including the rationale and future plans for the work done by these positions.*

The Washington Times article in December 2005 referred to the HUH reduction in force of 125 employees that took place on October 14, 2005. There have been no additional reductions in force since that time. The HUH workforce redesign initiative included management, clerical staff, aides, orderlies, technicians, specialists, and environmental and food service workers.

Registered nurses and other positions where labor shortages exist were excluded from the redesign initiative. Howard estimates that its workforce redesign strategic initiative will yield approximately \$9 million in savings on an annualized basis.

Prior to the redesign initiative, HUH's full time equivalent per adjusted occupied bed exceeded regional and national benchmarks for major teaching hospitals. The full time equivalent per adjusted occupied bed is a performance metric universally accepted by healthcare executives for measuring labor used to provide a day of hospital care. HUH's workforce redesign was necessary to operate at national standards and achieve best practices.

19. *Were the Medicaid reimbursement rates used in the financial calculations contained in the Mayor/Howard's July 12, 2005 submission to the Committee on Health the same as HUH's current rates?*

Yes. The current HUH Medicaid rates were used to calculate the NCMC revenues for anticipated patients covered under the District of Columbia Medicaid program.

20. *Please elaborate on the following from section 5.1.1 of the ERA:*

"The Grant Agreement shall acknowledge that a portion of Howard's share of the funding of the project Costs may be contributed by third parties and/or Howard University donations of services, equipment, and supplies, including HUH Assets transferred to the NCMC Hospital Site. The Grant Agreement shall provide that other HUH Assets transferred to the NCMC may be approved as a contribution by Howard, with the approval of the District". Does this mean that Howard plans to finance a portion of its \$212 million obligation by transferring services from HUH? Who are the third parties? What services, equipment, and supplies will be donated by HUH? How much will these donations account for? How much of Howard's obligation will be fulfilled by transferring services from Georgia Avenue to Reservation 13?

Also, please elaborate on the following from the same section:

"Further, the Grant Agreement shall specify the value of such donations of services, equipment, and supplies shall be determined and apportioned by mutual agreements between the parties."

Does this mean that the Grant Agreement will specify a dollar amount of services that HUH plans to dedicate towards its \$212 million obligation, or that such an amount may be agreed upon at some future time?

The question restates the ERA's summary of the Grant Agreement. The Grant Agreement has now been written and submitted to the Council for approval. Howard intends to utilize its full \$212 million contribution for the NCMC. However, it states in Section 2.3 that HUH assets transferred to the NCMC may be credited towards Howard's contribution. This provision was included to cover the remote contingency where equipment for NCMC is purchased and temporarily located at HUH prior to NCMC's opening, or where NCMC programs are developed at HUH while NCMC is under construction. Howard is currently engaged in a strategic planning process to optimize the configuration of services and programs at the NCMC and HUH. These plans will be fully described in the Preliminary Plan.

The District and Howard believe that the NCMC will be a national healthcare model that will attract contributions from third parties. Under the Grant Agreement, contributions from third parties may be used to offset NCMC capital costs and will be equally credited to each party's share of the Project Costs. It is premature to identify any third parties at this time.

The Grant Agreement does not specify a dollar amount of services that HUH plans to dedicate towards the \$212 million obligation. In fact, the Grant Agreement does not permit the value of HUH services to be used as an offset to Howard's \$212 million contribution.

21. *Please explain the following project costs as defined in section 4.5.2: "capital costs relating to the relocation of certain services from HUH to the NCMC Hospital."*

Should the Committee interpret this to mean that future renovations, build-outs, or other capital improvements made to HUH will be included in Howard's \$212 commitment for the NCMC? What services does Howard intend to move from the HUH?

No. Howard intends to utilize its \$212 million contribution for the NCMC Project. As described above, there is a strategic planning process to optimize the configuration of services and programs at the NCMC and HUH.

22. *Please explain the following project costs as defined in section 4.5.2: "or the placement of certain public health services of the NCMC at HUH." How should the Committee interpret this?*

During the negotiation of the ERA, the District and Howard agreed to develop the capabilities for involuntary acute psychiatric care at HUH so that the unit would be available prior to the construction and opening of the NCMC. If there are capital costs associated with the placement of the involuntary psychiatry care at HUH, rather than at the NCMC, they may be considered Project Costs.

NCMC CORPORATION

23. *According to section 2.1.3(iv), the Project Steering Committee is relegated to an advisory role to the Board of Directors of the NCMC Corporation after that corporation is officially formed. How will the District ensure that it does not lose representation on the construction and planning of the NCMC after that time?*

It is Howard's intent to abide by its commitment to a transparent and meaningful relationship with the Project Steering Committee. It intends to share all of the material developments and decisions with the Committee. Howard and the NCMC are embarking upon a long-term relationship with the District to better serve the healthcare needs of the District's residents in Northeast and Southeast Washington, D.C. It would be counterproductive for Howard to ignore the advice and counsel of the Project Steering Committee.

The Project Steering Committee's role will change to advisory in nature once the NCMC is formed, because the NCMC Board of Directors will have ultimate responsibility for the corporate and fiduciary actions of the new entity. However, before that occurs, the District will have approved the Preliminary Plans and the Development Agreement, and have enforceable

rights under the Project Documents (the Grant Agreement, Ground Lease, Development Agreement and ERA). As explained in Sections 4.3 and 5.3 of the ERA, the Development Agreement will be the culmination of the parties' design and pre-construction development work during the Planning Phase, whereby consensus is reached on the primary aspects of the construction project. The District and Howard will agree upon a mutually acceptable construction plan in the Development Agreement. The Project Steering Committee will be a resource for Howard and the District in the development of those documents.

It should be noted that the parties initially discussed an NCMC governance structure that would have provided for several Mayoral appointments to the NCMC board. However, the District's Office of the Attorney General later confirmed that it constitutes a conflict of interest for the Mayor to make appointments to a private board of directors.

The District will also have additional oversight opportunities with respect to the Project construction and planning through the District's zoning, permitting, licensing and LSDBE Memorandum of Understanding processes.

Finally, in the event that Howard fails to abide by its construction and planning commitments, the District has the enforcement rights summarized in response to Question 27.

24. *How will this corporation be structured?*

As stated in Section 4.3 of the ERA, the structure of the corporation will be developed by Howard and then shared with, and approved by, the District during the preliminary Planning Phase. At this time, the parties have committed to the formation of a separate and independent nonprofit entity with a long-term contractual affiliation with Howard. Until further decisions are made with regard to the status of HUH and the transfer of its assets, the final corporate structure cannot be determined. The governance plan for the NCMC will be approved by the District in the Preliminary Plan. In that plan, Howard intends to include representatives from the medical education, healthcare delivery and local neighborhood communities on the NCMC board, in addition to Howard Trustees.

25. *How will the NCMC Corporation be capitalized? Will the District be required to contribute? Will this come from the \$212 million obligation?*

The NCMC's long-term capitalization for construction will consist of the District's \$212 million contribution, and the proceeds of a tax-exempt bond issue collateralized by FHA mortgage insurance. The District is not expected to make a capital contribution beyond its contribution for construction. Under section 2.2.5 of the ERA, Howard has made a commitment to fund working capital for NCMC with the amounts to be defined in the Project Documents.

26. *If the NCMC Corporation borrows funds, will the District be required to guarantee funds? Will there be a tax-exempt bond issue or other form of financing from the District to capitalize the NCMC Corporation?*

The District will not be required to guarantee funds borrowed with the tax-exempt bond issue. The tax-exempt bond issue will be sold with the District as the conduit issuer for the

NCMC, similar to other conduit financings for nonprofit organizations in the District in which the District has no financial obligation.

REMEDIES

27. *What remedies would the District have in the event of default on the part of Howard?*

The District has included provisions for the enforcement of Howard's commitments in its Agreements with Howard. If Howard defaults under the ERA, the District will have the right to terminate the ERA or enforce the obligations under the terms of the ERA, the Grant Agreement and the Development Agreement. In addition, the District has the traditional enforcement mechanisms available to it through the zoning, permitting and regulatory enforcement actions.

The following are Events of Default under the Section 8.1 of the ERA: i) failure to perform any obligation required under the agreement; ii) failure to work on a good faith basis; iii) making an incorrect representation or warranty; and iv) failure to cure any Event of Default within thirty (30) days of receipt of the written notice of such default.

The Grant Agreement also gives the District the rights and remedies available at law or in equity for a material breach of Howard's covenant to undertake all necessary actions to comply with the NCMC Hospital Services and Plan, the HUH Services and Plan, and the Community Participation and Local Participation requirements set forth in the Preliminary Plan to be approved by the District.

After the Project is funded and the NCMC opens its doors, the public benefits remain enforceable under Article 4.2 of the Grant Agreement, which is intended to survive the termination of the funding of the Project for purposes of enforcing the public benefit commitments.

The right to terminate the Project once the Grant Agreement is funded is subject to the approval of any Lender involved.

The Development Agreement will address the design, development, funding and construction of the NCMC Hospital. The District will include appropriate enforcement provisions for the District in that agreement.

28. *What remedies would Howard have in the event of default on the part of the District?*

If the District defaults on its obligations in the Grant Agreement, Howard has the right to seek specific performance or termination at any time after an Event of Default.

29. *If, according to section 2.2.5, Howard is not subject to legal and financial exposure for the ongoing operations of the NCMC, who will be responsible for these risks?*

As noted in section 2.2.5 of the ERA, after an initial start-up period, the NCMC is intended to be a self-supporting, independent medical center with an independent board of directors overseeing its operations, much like the nonprofit institutions that own and operate most teaching hospitals across the county (e.g., Medstar in D.C., Partners in Boston). However,

as is also noted in section 4.3.3 of the ERA, the parties understand that during the initial years of operation, the NCMC may require working capital support, and Howard has made a commitment to fund working capital for NCMC with the amounts to be defined in the Project Documents. Beyond those initial contributions, the new entity will be solely responsible for its own legal and financial exposure, just like other nonprofit hospital organizations in the District and around the country.

30. *Finally, the success of its medical office building and research buildings are also tied to the success of the NCMC. If Howard's share of the NCMC is financed through an FHA loan, and the District's share is contributed through a grant(s) to Howard, the FHA will retain the lien on the NCMC in the event of a default by the NCMC Corporation. Will the District have any recourse to its \$212 million investment in this event or will the federal government own the entire hospital?*

The FHA will have as strong an interest in the success of the NCMC as the District and Howard. The hospital mortgage insurance program has been among FHA's most successful programs, largely as a result of its stringent underwriting and asset monitoring requirements, and protocols designed to avoid a loan default in the first place.

When FHA, in the course of its monitoring process, finds that a facility is beginning to experience financial difficulties and a default is threatened, FHA's loan covenants permit it to intervene in hospital management. For example, FHA may require a facility to retain a business consultant to work with the hospital to develop a strategy that restores sound financial stability. Recently, FHA worked successfully with three troubled New York facilities to either cure or prevent loan defaults. All three hospitals remain in operation today.

If, despite these initiatives, a facility nevertheless defaults with respect to its mortgage obligations, the underlying bond financing documents will require the FHA mortgagee to assign the mortgage to FHA, and pursue an insurance claim to protect the interests of bondholders. In that case, FHA will become the mortgagee of record with authority to consider the following default-related alternatives:

- FHA, in its capacity as mortgagee, may enter into a workout arrangement with the NCMC, modifying the terms and conditions of the previously insured mortgage to reflect a more viable payment structure. Alternatively, it may encourage the NCMC to consider affiliations and related arrangements with other community providers as a means of improving project feasibility. In either instance, the NCMC would continue to provide the medical services contemplated by its agreement with the District.
- FHA may foreclose its mortgage interest and succeed the NCMC as lessee under the District Lease, in which case FHA would also be subject to the terms and conditions of that Lease. In this event, FHA could either (a) retain a hospital management firm to continue hospital operations, to the same effect as above, e.g. community medical services would continue to be available, or (b) exercise its rights as tenant to transfer, sell or assign its leasehold interest to a third party. In the latter instance, the District would be able to protect its investment through the exercise of the District's right of first refusal under the Lease to purchase the leasehold interest. Once the District exercises its right of

first refusal, the District can continue hospital operations if it so desires, or use the site as it otherwise finds in the interest of District residents.

In the past, FHA's review of these options included careful consideration of the interests of all parties to the project, including the community.

MISCELLANEOUS

31. *The HUH currently maintains a number of collective bargaining units. Will these bargaining agreements be transferred to the NCMC?*

The parties fully expect the NCMC to partner with its employees and their union representatives and expect employees of the NCMC to be appropriately represented. The NCMC will determine whether this is best done by transferring current HUH collective bargaining units or creating new ones. The NCMC will make that decision at the appropriate time, in consultation with the unions.

32. *Please provide the Committee copies of fiscal year audits performed for both Howard and HUH for the past five fiscal years?*

The audited financial statements of Howard (which are publicly available) and HUH (whose statements are not public documents) for the fiscal years 2000 through 2005, which are in total over 100 pages, are being provided to the Council Chairman and the Committee Chair.

33. *Please provide the accreditation status since 2000, including periods of probation, for each department within the HUH as determined by the American Council for Graduate Medical Education, Joint Commission on Accreditation of Healthcare Organizations, and other accrediting organizations.*

No HUH Departments have ever been placed on probation by an accrediting program.

Academic Medical Centers may be reviewed by as many as four different accrediting bodies:

Hospitals are accredited by The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO measures organizations against standards that emphasize operational safety and quality of patient care. JCAHO also examines healthcare organizations for compliance with performance expectations, termed elements of performance (EPs). Over a thousand EPs covering various areas of concentration are reviewed. HUH has always enjoyed full accreditation by this body, scoring 93 out of 100 in 1999, and 94 out of 100 in 2002. In 2004, JCAHO changed the way it evaluated healthcare organizations. Instead of using numerical scores, hospitals are either accredited or not. HUH was surveyed under these new standards in May 2005, and was granted full accreditation.

The American College of Surgeons (ACS) accredits Trauma Centers. Level One is the highest level obtainable, meaning that such centers are verified to treat the most complex trauma cases. HUH is one of only three ACS Verified Level One trauma centers in the District, and it

was the first area hospital to receive ACS Level One trauma verification during the most recent cycle of assessment.

The Liaison Committee on Medical Education (LCME) is the accrediting body for medical schools. Howard's two most recent surveys occurred in 1994 and 2002. Howard's College of Medicine is fully accredited.

The Accreditation Council for Graduate Medical Education (ACGME) is the body which reviews physician residency training programs against standards to ensure the ability of a program to train postgraduate physicians to practice competently and independently. HUH enjoys a favorable institutional status by the ACGME. Howard has 19 residency programs that are accredited - the six programs required for Medical School accreditation, and thirteen others.

<u>PROGRAMS REQUIRED FOR MEDICAL SCHOOL</u>	<u>ACCREDITED</u>	<u>PROBATION</u>
Family Medicine	YES	2000-2002
Internal Medicine	YES	NA
Obstetrics/Gynecology	YES	NA
Pediatrics	YES	NA
Psychiatry	YES	NA
Surgery	YES	NA

OTHER TEACHING PROGRAMS

Cardiology	YES	NA
Dermatology	YES	NA
Endocrinology	YES	NA
Gastroenterology	YES	NA
Hematology	YES	NA
Infectious Disease	YES	NA
Medical Oncology	YES	NA
Neurology	YES	NA
Ophthalmology	YES	NA
Orthopedic Surgery	YES	NA
Pathology	YES	2001-2005
Psychology	YES	NA
Pulmonary Disease	YES	NA

34. Please define "mental health and substance abuse intake" as used in section 4.3.4 of the ERA. Does this mean that there will be a defined number of beds for substance abuse in the NCMC? If so, how many?

NCMC will not have a defined substance abuse unit, but it is expected that patients may seek services at the NCMC's emergency room. "Mental health and substance abuse intake" as

used in section 4.34. of the ERA refers to the procedures that the NCMC will use when someone presents at the ER seeking behavioral health services, and/or when, subsequent to treatment, a patient is diagnosed with a mental health or substance abuse condition. An intake plan will be developed that describes the NCMC's process for triaging such patients to the appropriate provider based on their needs. Such providers may include HUH's Mental Health Unit or the District's Detoxification Unit. The intake plan will ensure that there is a seamless transition from the ER to the most appropriate inpatient acute or outpatient behavioral site for further treatment, as needed.

35. *Will the District's Detoxification Unit and Sexually Transmitted Disease Clinic, both of which currently reside on Reservation 13, be incorporated into the NCMC?*

No. The NCMC project places these services in a new public health/District government office building on Site L of Reservation 13 (located adjacent to the jail along the south side of the Massachusetts Avenue extension). This new building will house the Detoxification Unit, the Sexually Transmitted Disease Clinic, the Tuberculosis Clinic, and other substance abuse services that are now located on the Reservation 13 campus. These services will continue to be operated as public health services by the District of Columbia. The public health services will require roughly 100,000 square feet of space. However, the site will allow for roughly 325,000 square feet of space. The balance of the square footage will be used as general District government office space, with tenants to be determined (e.g., Department of Health, Department of Corrections). The building will be privately financed and developed by the Anacostia Waterfront Corporation. The financing will be secured by a long-term lease from the District's Office of Property Management.

The NCMC will provide a range of services to support the District's new site, including care coordination that may include clinical staff and/or administrative support, as mutually agreed upon by the parties.

36. *Why is it necessary to specify that information related to the project, including plans and financial projections, is proprietary and not available for public scrutiny as is done in section 2.1.3 (ii)? What is the precedent for stipulating this, especially as it pertains to large-scale public projects?*

Protection of Howard's proprietary and confidential business plans and information is necessary to assure open dialogue and information sharing with the District and the Project Steering Committee during the Preliminary Planning phase of the project; and to comply with contractual non-disclosure provisions contained in many of Howard's vendor relationships. The assets of a corporation include more than just tangible materials; they also include goodwill, intellectual property and trade secrets. The competitive nature of the healthcare industry and Howard's contractual obligations make the operations of HUH, as a private institution, proprietary. Howard is also subject to numerous confidentiality provisions that would be breached were Howard to disclose certain information about its practices and contract provisions. In addition, it is not a constructive exercise, nor an efficient use of time and resources to divulge to the public unexecuted drafts of any of the agreements contemplated by this transaction. It is in the best interests of both the public and the parties to these agreements to keep the discussions in strict confidence to ensure that a complete, fair and accurate picture is

presented. It is a well-known and common practice for certain information to be kept in Executive Session, in accordance with specific exceptions to the Sunshine Laws. Disclosure of trade secrets, commercial or financial information is a pertinent exception to the Sunshine Laws, which promote the voluntary furnishing of reliable information to government bodies. Notwithstanding such laws, the public will have access to the information that impacts them at the conclusion of this process when any actions adopted are subsequently disclosed to the public. Further disclosure of the details of this transaction during the planning phase could impede progress, and open all parties involved to a competitive disadvantage.

37. *Will the Grant Agreement specify precisely what liabilities and assets Howard intends to transfer from HUH to the NCMC? Why would liabilities need to be transferred?*

The Grant Agreement, which is part of the legislative package submitted to Council in early February, does not include the specific HUH assets and liabilities that will be transferred to the NCMC. Depending on the nature of the assets that are assigned from HUH to the NCMC, certain related liabilities may also need to be transferred. For example, an equipment lease or service agreement is a liability that would be transferred with the corresponding equipment. These specifics will be included in the Preliminary Plan.

38. *At the Committee's three hearings on the NCMC in 2005, the City Administrator said:*

- *"Over the course of the next several months, I plan to work with Howard to finalize these arrangements so that we can bring the entire package to Council by this summer." [February 17, 2005]*
- *"By this Fall, the Mayor will introduce legislation for Council action." [July 13, 2005]*
- *"We will introduce this ERA to Council once it has been approved by Howard's Board of Trustees. The Board is set to meet on November 18th, and the Mayor will introduce legislation shortly thereafter." [October 28, 2005]*

The Council received a signed copy of the ERA Thursday, January 5, 2006. To date, however, no legislative package has been submitted to the Council. Who are the individuals, in both the District government and at Howard, responsible for completing this agreement, drafting the legislation, and submitting the final package to the Council?

The NCMC is a complex project involving two parties and three major negotiated agreements. The NCMC plan and the provisions of each of these agreements required the approval of the Howard Board of Trustees, which held a two-day special retreat in November 2005, to address these issues. At the most recent Committee of Health Public Roundtable on the NCMC in October 2005, Howard officials committed to communicating the Board decision about the NCMC prior to Thanksgiving, 2005. This deadline was met. At the same hearing, the City Administrator committed to completing the NCMC agreement by January 1, 2006. The ERA was completed by the two parties on December 30, 2005 and signed by Mayor Williams and President Swygert on January 3, 2006, the first business day after January 1st. At a ceremonial signing of the ERA on January 5, 2006, the Mayor committed to introducing a full legislative package by February 7, 2006. Five of the six bills were submitted on February 6th,

and the final piece of legislation on February 9th. The Mayor and the President of Howard are ultimately responsible for this final legislative package, now before the Council.

39. *According to Title IV of the ERA, even after Council approval of the initial legislative package (i.e., the ERA, Grant Agreement, Ground Lease, and CON exemption) no less than five additional plans would need to be agreed upon after Council approval of ERA in 120 days*

1. *the NCMC Governance Plan [4.3.1]*
2. *Project Business Plan [4.3.3]*
3. *Hospital Space Plan [4.3.4 (I)]*
4. *the NCMC Hospital Services and Plan [4.3.4 (ii)]*
5. *HUH Services and Plan [4.3.4 (iii)]*

What happens if the 120-day deadline for the completion of all five of these plans is missed? Will these plans be submitted to the Council for its review and approval? If not, why not?

Under the ERA, the District and Howard are to complete the five plans within 180 days of the Council's approval of the ERA, Grant Agreement, Ground Lease and CON exemption legislation (120 days, plus two 30-day periods). Howard has 120 days from the date of Council's approval to submit its draft of the Preliminary Plan to the District. The District will review and comment on the Preliminary Plan within 30 days of its receipt. Howard then has 30 days from receipt of those comments to complete the revisions, and re-submit the revised materials to the District for its approval. After the initial 180-day period, the parties may extend the time by mutual agreement; however, both parties agreed to work diligently to keep within these deadlines, due to the need to adhere to the financing and construction timeline.

The ERA does not require Council approval of the detailed Preliminary Plan documents. This process is consistent with the respective administrative and legislative responsibilities of the District and Council.